

HHSA Ten Year Roadmap Behavioral Health Services

Accomplishments: Year One

In July 2016, Health and Human Services Agency (HHSA)/Behavioral Health Services (BHS) presented the Ten Year Roadmap – a major endeavor which seeks to address the most serious behavioral health issues affecting San Diego County over the next ten years. The goal of the Roadmap is to guide BHS planning to provide quality behavioral health services and to empower individuals with behavioral health needs to live healthy, safe and thriving lives. The Roadmap is a dynamic, living document, updated annually to incorporate new priorities from our community partners and HHSA/BHS leadership.

| OUR VISION, MISSION AND VALUES | OUR GUIDING PRINCIPLES | OUR COMMITMENT |
|---|---|---|
| <p>Vision: <i>Live Well San Diego</i> – A region that is Building Better Health, Living Safely and Thriving</p> <p>Mission: To efficiently provide public services that build strong and sustainable communities</p> <p>Values: Integrity – Stewardship – Commitment</p> | <p>Promote Recovery, Resiliency, Discovery and Well-Being; Provide Trauma-Informed and Culturally Competent Services; Collaborate with Partners, Stakeholders and the Community; Maximize Funding; Make Data Driven Decisions; Ensure Regulatory Compliance; Utilize Evidence Based/Informed Practices; Embrace Diversity and Inclusion</p> | <p>Work in partnership with our communities to provide quality behavioral health services that empower individuals with behavioral health needs to live healthy, safe and thriving lives.</p> |

The table below outlines the **Accomplishments** for the Roadmap in Year One (Fiscal Year 2016-17) as related to **12 Priorities**. Each **Priority** is guided by a **Ten Year Vision** with clear **Strategies** that outline our efforts to accomplish the Vision. The Ten Year Roadmap and Year One Accomplishments can be found on the Network of Care: www.sandiego.networkofcare.org/mh (click on **HHSA/BHS Ten Year Roadmap**).

| TEN YEAR ROADMAP ACCOMPLISHMENTS: YEAR ONE <i>Fiscal Year 2016-17</i> | |
|--|---|
| <p>Aging Population</p> <ul style="list-style-type: none"> ○ Vulnerable older adults with serious mental illness receive integrated, geographically accessible, age-appropriate services to address their complex needs. <ul style="list-style-type: none"> ◆ Support caregivers in their role and prevent the onset or progression of their mental health conditions by educating and connecting them to resources. <ul style="list-style-type: none"> ➤ Expanded the Caregivers of Alzheimer's Disease and other Dementia Clients Support Services program countywide to provide prevention and early intervention services which educates and connects caregivers to mental health resources and training, serving 302 caregivers who reported 97% satisfaction in classroom training ◆ Continue and expand training of geriatric specialist staff to include early identification of cognitive deficits in older adults receiving treatment in mental health programs. <ul style="list-style-type: none"> ➤ Held two geriatric training academies with 37 graduated ➤ Held two geriatric trainings specific to hoarding and sexuality with 26 in attendance <p>Care Coordination</p> <ul style="list-style-type: none"> ○ Persons with serious mental health and/or substance use disorders have all needs met in a timely manner through an integrated continuum of care. <ul style="list-style-type: none"> ◆ Apply whole person-centered principles to intensify and further develop care coordination models that are tailored to the needs and level of care for the individual. <ul style="list-style-type: none"> ➤ San Diego County Psychiatric Hospital established a Person Centered Care pilot to model Whole Person Wellness principles and strategies in preparation for wider implementation throughout our system of care ➤ Collaboratively developed and disseminated training material for a Warm Handoff model to effectively coordinate care and successfully transition clients | <p>Priority</p> <ul style="list-style-type: none"> ○ Ten Year Vision <ul style="list-style-type: none"> ◆ Strategy <ul style="list-style-type: none"> ➤ Year One Accomplishment |

Care Coordination (continued)

- ◆ Promote integration of Whole Person Wellness by advancing relationships with the community including private, public, family, consumer and education partners.
 - Through the Continuum of Care reform efforts, the Child and Family Team (CFT) concepts were expanded with an emphasis on bringing together all the individuals who care for a child/youth to support their success
- ◆ Utilize and broaden the use of various IT systems, including ConnectWellSD and San Diego Health Connect, to promote care coordination and to offer those in need of services innovative platforms including digital solutions.
 - Participated in ConnectWellSD planning and testing to promote coordinated care for mutual clients within HHSA
 - BHS staff participated in the San Diego HealthConnect Behavioral Health workgroup to promote timely and appropriate healthcare information sharing across the community

Children and Youth Population

- Children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families.
- ◆ Ensure a full continuum of care through family-centered and youth-informed services that are compassionate and sensitive to the unique developmental needs of children and youth.
 - Initiated specialized services for Commercially Sexually Exploited Children (CSEC) in the juvenile institutions, adding this specialty to the array of services available under the County Behavioral Health system and furthering our partnership with the Courts and Probation
- ◆ Provide services that empower children and youth to build a healthy sense of self and have confidence to make sound decisions so they thrive in an ever-changing world.
 - Developed and delivered eight sessions of 'Understanding and Diagnosing Complex Behavioral Health Conditions' to train practitioners within the system of care
 - Under Continuum of Care Reform and in partnership with Child Welfare Services and Probation, the Child and Family Team (CFT) convening was expanded to incorporate family voice in key stages of system involvement
 - Completed the third and final phase of shifting outpatient clinics to Full Service Partnership programs that offer a comprehensive multidisciplinary team to support the child/youth and their family
- ◆ Strengthen partnerships with children/youth's circle of influence to create a supportive environment.
 - Hosted the 3rd Annual Children's Mental Health Well –Being Celebration, a community event that brought local attention to the National Children's Mental Health Awareness Week

Crisis Services

- All persons experiencing a psychiatric emergency have access to timely and appropriate services to ensure their safety and that of the community.
- ◆ Develop a service model that ensures timely, trauma-informed, culturally-competent crisis intervention services while considering the unique needs across the lifespan.
 - Implemented two Crisis Stabilization Units in North County
 - Implemented a new Crisis Residential Treatment program in North Inland region
 - Added ten new Psychiatric Emergency Response Teams (PERT), bringing the total to 50
- ◆ Utilize community-based, peer-driven and family-informed crisis intervention models to reduce the reliance on law enforcement intervention and emergency department utilization.
 - Expanded walk-in, urgent care program for adults in North Region from one location to two
 - Implemented a recidivism tracking system to support follow up connection with youth who received stabilization services
- ◆ Ensure all crisis centers can serve as a point of entry in the full continuum of care.
 - Awarded grant funding from the California Health Facilities Finance Authority to build a central location, expanded, crisis stabilization facility for youth
 - Expanded access points for clients to the overall system of care through the addition of two new Crisis Stabilization Units, a Crisis Residential Treatment program and the upcoming Crisis Stabilization Units for youth

Homeless Population

- All persons with serious mental health and/or substance use disorders who are experiencing homelessness have treatment and housing to support their recovery.
- ◆ Ensure the appropriate level of care for persons experiencing homelessness and implement an array of housing options that promote community integration.
 - Implemented 245 treatment slots for homeless persons with Serious Mental Illness in support of Project One for All, as well as 145 treatment slots for homeless persons with Substance Use Disorders

Priority

- ◆ Ten Year Vision
 - Strategy
 - Year One Accomplishment

Homeless Population (continued)

- Housed 396 clients with Serious Mental Illness in permanent housing and bridge housing
- Added outreach and engagement services for 800 people in mental health and substance use disorder treatment programs to assess persons who are homeless and connect to appropriate BHS services and housing resources
- ◆ Work in partnership with housing authorities and developers to acquire permanent supportive housing.
 - Paired 373 housing vouchers from San Diego Housing Commission (SDHC) and Housing and Community Development Services (HCDS) with BHS-contracted Full Service Partnership (FSP) Assertive Community Treatment (ACT) programs that serve homeless clients
 - Connected 59 homeless BHS clients in outpatient treatment with HCDS housing vouchers
 - Worked closely with housing partners to increase permanent housing stock for clients enrolled in FSP/ACT and outpatient mental health programs resulting in the creation of 47 permanent supportive units for BHS clients at the Hotel Churchill and Atmosphere housing developments (under the MHSA housing program)
- ◆ Reduce stigma through education, as well as incentivize and collaborate with landlords to increase housing inventory.
 - Worked with Housing and Community Development (HCDS) to educate and incentivize landlords to secure permanent supportive housing by offering a robust package to those who rent to formerly homeless persons that are connected with BHS services and have received an HCDS housing voucher

Justice-Involved Population

- Persons with serious mental illness or substance use disorders who are justice-involved have access to integrated treatment and supportive services to increase public safety and reduce recidivism.
 - ◆ Increase access and connectivity between the justice system and behavioral health to ensure clients are receiving the appropriate level of care.
 - BHS and Justice Partners continued to work together through the Stepping Up Initiative, adopted by the Board of Supervisors in November 2016, to address gaps in service and work toward an overall reduction in persons with mental illness who are incarcerated in County jails
 - South Region Behavioral Health Review Calendar pilot program launched in January 2017 to follow participants in treatment to support stabilization and probation compliance
 - Partnered with the Public Safety Group in the development of program implementation as part of Prop 47 grant which was awarded to the County in May 2017
 - Collaborated with the Public Defender's Office on the Defense Transition Unit (DTU) Program with embedded BHS clinicians identifying and linking in-custody persons diagnosed with Serious Mental Illness with community providers
 - ◆ Deliver best practice services demonstrated to improve wellness and reduce recidivism for justice-involved individuals, including those transitioning from custody to the community.
 - Implemented and conducted eight Correctional Program Checklists (CPCs) to assess utilization of evidence-based practices to address criminogenic need among our substance use disorder and mental health programs
 - Partnered with Sheriff to design the PROGRESS Program, a residential program that will serve persons coming out of custody with mild to moderate mental illness and co-occurring diagnoses
 - Expanded Project In-Reach Program to offer in-custody engagement and bridging services in the community to individuals with Serious Mental Illness
 - Implemented a Faith-Based bridging program for individuals in custody with Serious Mental Illness
 - Conducted focus groups which included justice partners, service providers and individuals receiving services while in custody
 - ◆ Evaluate impact and pursue process improvement using standard data and definitions to improve outcomes and support recovery.
 - Initiated training for community providers in ASAM and Medication Assisted Treatment (MAT) criteria to enhance treatment matching

Long-Term Care

- Persons receiving treatment for serious mental illness in long-term care settings successfully reintegrate into the community.
 - ◆ Support recovery in the least restrictive level of care.
 - Expanded bed capacity and extended contract lengths of long-term care programs that serve as alternatives to higher levels of care
 - ◆ Strengthen existing transitional step-down care to maximize the individual's reintegration into the community.
 - Increased bed availability at a behavioral health residential treatment program which serves as an alternative to Institution for Mental Disease (IMD) and is a step-down placement for those being discharged from IMDs and the State Hospital

Priority

- Ten Year Vision
 - ◆ Strategy
 - Year One Accomplishment

Long-Term Care (continued)

- ♦ Evaluate and develop preventative treatment and housing strategies to minimize the need for long-term care.
 - Developed and implemented the Long-Term Care Expansion Plan which increases capacity at lower levels of care (shifting from dependence on acute care) and treats people at the least restrictive level of care

Organized Delivery System for Substance Use Disorders

- An integrated, whole person system of care that utilizes best practices based on an individual's specific needs and within the appropriate level of care to promote successful recovery.
 - ♦ Support those on the recovery journey by implementing best practices to increase access, ensure treatment effectiveness and improve outcomes.
 - Developed and submitted the 1115 Waiver Drug Medi-cal Organized Delivery System implementation plan, which will create a broader care network and achieve higher levels of care coordination and access to person-centered services
 - Established standards for full integration of persons utilizing medication assisted treatments
 - Established standards and training opportunities to adopt the use of evidenced-based clinical tools to create a whole person assessment and person-centered treatment plan
 - ♦ Promote a culture of acceptance for persons needing services.
 - Adopted person-centered and recovery-oriented language into all Substance Use Disorder related communications
 - ♦ Advocate for federal legislative change to allow for appropriate, timely sharing of vital health information to optimize quality care.
 - Developed staff expertise around updated federal regulations for information sharing specific to Substance Use Disorder medical records

Prevention

- All persons are connected within their community and empowered to take action before there is a need.
 - ♦ Pursue policy and community change to ensure all persons live in an environment free of substance use harm.
 - Updated County Substance Abuse Prevention Plan guiding our collective efforts to eliminate youth access to alcohol and other drugs
 - Provided briefings to BHAB, our Councils and BHS teams to educate about the impact of Prop 64 which was passed on 11/8/16
 - ♦ Champion efforts to train individuals to be able to recognize and support fellow community members impacted by mental health and/or substance use issues.
 - Released the 2016 Meth Strike Force Report Card and the 2016 Prescription Drug Abuse Report Card, detailing the impacts of substance use on our communities
 - In partnership with Public Health Services, developed and implemented the Healthy Retail Program in the City of San Diego
 - Sponsored the annual May is Mental Health Awareness Campaign engaging HHSA staff to reduce stigma and discrimination for mental illness
 - ♦ Foster communities free of stigma in which persons affected by mental health and/or substance use issues are able and willing to seek services.
 - Added additional Victims of Crime resources to the Community Violence program which provides relevant training to organizations as well as support services to individuals and families who have been victims of crime
 - Conducted Meth Strike Force *Tip the Scale* events that provided drug treatment conversations and drug treatment to individuals who are found non-compliant
 - Increased Mental Health First Aid (MHFA) trainings to colleges, schools, faith-based organizations, law enforcement and many community organizations, totaling 4,591 individuals trained in MHFA
 - Expanded stigma reduction and suicide prevention outreach campaign to include focused outreach to Latino populations, LGBTQ, veterans and older adults

Suicide Prevention

- There are zero suicides in San Diego County.
 - ♦ Foster an ongoing expectation of organizations to implement zero suicide strategies.
 - Expanded school-based suicide prevention services countywide with an added bullying prevention component
 - Supported suicide prevention efforts for probation-involved youth through trainings and establishment of referral pathways
 - ♦ Advance goals consistent with the recommendations from the San Diego County Zero Suicide Strategic Plan.
 - Updated the San Diego County Suicide Prevention Action Plan for the next five year period.
 - Provided training to over 38,000 community members countywide to enhance community awareness of the warning signs of suicide and mental health crises so individuals can refer those at risk to available resources

Priority

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Suicide Prevention (continued)

- Implemented the Behavioral Health Advisory Board Suicide Prevention Workgroup (SPW) recommendations identified in the SPW Feasibility Report, including the use of the Columbia Suicide Severity Rating Scale (C-SSRS)
- ◆ Leverage innovative methods to measure the impact of prevention and intervention strategies.
 - Longer term strategy

Unserved and Underserved Populations

- Diverse unserved and underserved communities are aware, empowered and able to access services appropriate to their unique needs.
 - ◆ Recognize the impact of social determinants of health, disproportionality and health disparities to align prevention and systems of care strategies.
 - BHS leadership engaged in refugee and East African Community forums to discuss needs, gaps and strategies among these communities
 - Amended Substance Use Disorder prevention contracts to build capacity and incorporate learnings regarding Adverse Childhood Experiences (ACEs) into current work with community
 - ◆ Foster an inclusive, accepting and culturally-competent environment that celebrates diversity.
 - BHS led multiple cross sector discussions about immigration anxiety and its impact on children, youth and families, with the intention of increasing awareness and sharing resources
 - 200+ individuals participated in training at annual BHS conference, *Honoring the Journey: Partnering with Refugee Families*
 - Trained 240 “cultural brokers” representing the African-American, Latino, African immigrant/refugee, Native American and LGBTQ communities to be able to identify mental health disparities, stigma, and discrimination
 - ◆ Offer culturally relevant and accessible services to address the needs of diverse populations.
 - Developed and procured two new programs to support LGBTQ youth and youth who are (or have been) commercially sexually exploited; start date of services 7/1/17
 - Fully embedded prevention and early intervention services at all DUI programs

Workforce

- Our system of care has a skilled, adaptive and diverse workforce that meets the needs of those we serve.
 - ◆ Advocate for policies and processes that establish innovative recruitment, hiring and retention of a skilled and diverse workforce.
 - BHS conducted the third biennial workforce assessment survey in September 2016 to describe current workforce and identify areas of need
 - Transitioned the UCSD Community Psychiatry Program into a residency track model to further enhance interest in working within the public behavioral health system
 - ◆ Pursue team based care and innovative workforce solutions to increase access, improve outcomes and increase efficiency.
 - Contracted services to offer recovery-oriented, countywide training to transition age youth, adults and older adults to become Peer Specialists for the County of San Diego public behavioral health system
 - Developed an enhanced training curriculum for psychiatric nurses staffed at our inpatient psychiatric hospital
 - Provided three educational events for community-based primary care providers to support their integrated and team based care behavioral health services
 - ◆ Develop a career ladder for assisting individuals with lived experience in competitive employment as well as designated peer positions.
 - Individuals with lived experience participated in a focus group to assess current job satisfaction in the BHS system of care and discussed best practices/challenges

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Partner Accomplishments

Audacious visions are made possible by the collective activities of our behavioral health partners. Please see Fiscal Year (FY) 2016-17 achievements below submitted for inclusion in this Roadmap Accomplishments document.

- On March 13, 2017, **Southern Indian Health Council, Inc.** opened the first Native Services Boys & Girls Club in California. The Club offers a computer lab, music room, physical activities, homework support and more.
- **Southern Indian Health Council, Inc.** developed and hosted a number of Suicide Prevention Leadership Summits which included key community leaders who, on behalf of the underserved population of the Native Americans in the East County Region of San Diego, have set a goal to address service gaps in responding to suicide attempts. Activities to achieve the goal include ongoing discussions, resource gathering and strategic partnerships.
- Multi Ethnic Community Health Workers through **Union of Pan Asian Communities’ (UPAC) Elder Multicultural Access and Support Services (EMASS)** program provided outreach, engagement and education to 953 underserved seniors on wellness and self-management for prevention and early intervention of mental illness. Seniors included monolingual/bilingual Latinos, Filipinos, Iraqis, Somalis and African Americans.